

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06803

06802

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) Christy Deaver First Middle Last		4. DATE OF DEATH Month May Day 11 Year 1966	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1884
9. AGE (In years lost birthday) yrs. 81		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Penna.	
13. FATHER'S NAME Benjamin F. Deaver		14. MOTHER'S MAIDEN NAME Ladd Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-22-9052	
17. INFORMANT Mrs. Annie Boyd, North East, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage DUE TO (b) Carcinoma of the stomach DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 151X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 hrs. Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 12, 1965 to May 11, 1966 , that (I) (we) last saw the deceased alive on May 11, 1966 , and that death occurred at 11:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE S. Ralph Andrews, Jr.		22b. DATE SIGNED 5/11/66	
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		22d. ADDRESS 235 E Main St., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 14, 1966	
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City or Town) (County) (State) Conowingo, Md. Cecil	
24. FUNERAL DIRECTOR Lee A. Patterson, Son		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Perryville, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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21 Sept 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF TIME IN 1b 7 yrs 8 mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Suitland, Maryland d. STREET ADDRESS 3938 Suitland Road, Apt 202 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) VERNON M. BELL			4. DATE OF DEATH May 2 19 66							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-23		9. AGE (In years last birthday) 42 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Arlington, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Grover C. Bell					14. MOTHER'S MAIDEN NAME Bessie Laura XXX DuVal					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II			16. SOCIAL SECURITY NO. 578-20-5312		17. INFORMANT VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 6921 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abscess of right chest wall DUE TO (c) Chronic progressive chorea (Huntington's Chorea) 9 yrs								INTERVAL BETWEEN ONSET AND DEATH 5-10 days 5-10 days 9 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept. 2 , 19 58 , to May 2 , 19 66 and that death occurred at 4:40 from the causes and on the date stated above.										
22a. SIGNATURE S. Goldgraben				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5-2-66				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.				22d. ADDRESS VA Hospital, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Removal & Burial		May 4-66		Cedar Hill Cemetery			Suitland, Maryland.			
24. FUNERAL DIRECTOR Simmons Bros				ADDRESS SE, Wash., DC			25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

06811

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06804

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Newark RD# 2	
3. NAME OF DECEASED (Type or print) First Middle Last Gerald T. Borchardt		4. DATE OF DEATH Month Day Year May 7, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1911
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist-Market analyst DuPont Co.		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick H. Borchardt	
14. MOTHER'S MAIDEN NAME Lucia Tennyson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 356-07-9038		17. INFORMANT Mrs. Dorothy M. Borchardt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byers, M.D.		22. DATE SIGNED 5-8-66 Elkton, Md.	
EXAMINER'S NAME (Type) John M. Byers, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1966	
23c. NAME OF CEMETERY OR CREMATORY Head of Christiana		23d. LOCATION (City or Town) (County) (State) Newark, Delaware	
24. FUNERAL DIRECTOR R. T. Jones		25. REGD BY REGISTRAR May 16 1966	
ADDRESS Newark, Del.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md. c. LENGTH OF STAY IN b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1343 Wallach Place, N.W.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CLINTON First Middle Last CLINTON NMI CRAWFORD			4. DATE OF DEATH May 23 19 66 Month Day Year							
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-93 yrs.		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Yard Helper			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Rock Hill, N. Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Crawford (D)			14. MOTHER'S MAIDEN NAME Mary Johnson (D)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW 1 578-46-6613		17. INFORMANT VA Hospital Records, Perry Point, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from May 11, 19 66, to May 23, 19 66, and that death occurred at 2:35 M, from the causes and on the date stated above.										
22a. SIGNATURE S. Goldgraben			22b. DATE SIGNED 5-23-66 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.			22d. ADDRESS VA Hospital, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 5/26/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Ft. Meade Md.			
24. FUNERAL DIRECTOR Johnson & Jenkins Funeral Home, Washington,			ADDRESS D.C.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

MAY 25 1966

Charles Judge

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MEDICAL CERTIFICATION

06813

Item 2 See birth cert. ams. 6-6-66

CERTIFICATE OF DEATH

06806

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Del. Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 20 mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 10 Russell Street R.D. 1/2, Box 101		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kevin Middle J. Last Earl				4. DATE OF DEATH Month May Day 13 Year 1966			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1966		9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Earl				14. MOTHER'S MAIDEN NAME Coleena Owens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) noen		16. SOCIAL SECURITY NO.		17. INFORMANT Address Howard Earl-R.D.2-Box 40, Nwk, Del?			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7735 IMMEDIATE CAUSE (a) Respiratory failure - Prematurity DUE TO Tumor mass on Neck compressing Resp. tract. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 61 minutes after birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/13/66	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/66		23c. NAME OF CEMETERY OR CREMATORY St. Daniels Cem.		23d. LOCATION (City or Town) (County) (State) Iron Hill, Del.	
24. FUNERAL DIRECTOR Charles Belle				ADDRESS 909 Poplar St.		25a. REC'D BY REGISTRAR MAY 17 1966	
				25b. REGISTRAR'S SIGNATURE 			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Ridley Park	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 11 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County		d. STREET ADDRESS 411 Perry Street	
3. NAME OF DECEASED (Type or print) Jack E. Fallin		4. DATE OF DEATH Month May Day 28 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 8, 1904
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUN OIL CO.		10b. KIND OF BUSINESS OR INDUSTRY MACHINIST	
11. BIRTHPLACE (County & State, or foreign country) Reed Villa, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME —		14. MOTHER'S MAIDEN NAME —	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 222-07-2159	
17. INFORMANT ELLA. J. FALLIN - RIDLEY PARK, PA.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary occlusion with posterior myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 28 10 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 28 May, 19 66 to 28 May, 19 66 that (I) (we) last saw the deceased alive on 28 May 19 66 , and that death occurred at 4 PM , from causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 28 May 66	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 4, 1966	23c. NAME OF CEMETERY OR CREMATORY WOODLANDS CEMETERY	23d. LOCATION (City or Town) (County) (State) PHILA. PENNA.
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. READ BY REGISTRAR 2 JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00803

CERTIFICATE OF DEATH

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Philadelphia

Coall

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Union Hospital of Coall County

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06815

CERTIFICATE OF DEATH

06808

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton. R.D.1 07-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Inice Ella Haley		4. DATE OF DEATH Month Day Year May 29, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1905
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Wyeth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-22-5073A	
17. INFORMANT Mrs. Pauline Prewitt, Oxford, Pa. R.D. 1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchogenic Carcinoma, 1 lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 1621		INTERVAL BETWEEN ONSET AND DEATH Approx 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) Carcinoma, Cervix. Treated with irradiation			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-24- 19 66 , to 5-29- 19 66 , that (I) (we) last saw the deceased alive on 5-29-66 19 66 , and that death occurred at 11:45 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>William D. Johnson</i>		22b. DATE SIGNED 5-30-66	
22c. PHYSICIAN'S NAME (Type) William D. Johnson M.D.		22d. ADDRESS 123 S. Sagerly Ave., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May, 31, 1966	23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery	23d. LOCATION (City or Town) (County) (State) Galena, Kent Co; Md.
24. FUNERAL DIRECTOR Edward Fellows, Millington, Md.		25a. REC'D BY REGISTRAR JUN 1 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

158808

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REPORT OF DEATH

Death

Death

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
MAY 31 1966

Death

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06816

CERTIFICATE OF DEATH

06809

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 28 days 3 yrs 5 mos		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital				d. STREET ADDRESS 513 N. Mulberry St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert L. Harman		4. DATE OF DEATH Month Day Year May 19, 1966							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7 8 02		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RIVETER		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Garfield J. Harman				14. MOTHER'S MAIDEN NAME Carrie R. Brill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 219-12-00-70		17. INFORMANT VA Hospital Records - Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 12-18 hours years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (d) (this hospital) attended the deceased from 11 9 62, 19 to 5 19 66, 19, and that death occurred at 8:40 pm, from the causes and on the date stated above.									
22a. SIGNATURE S. Goldgraben				22b. DATE SIGNED 5 20 66					
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.				22d. ADDRESS VA Hospital - Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/23/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR Charles M Rouzer Rouzer Funeral Home, Hagerstown, Maryland Per T. Sullivan Coffinbearer				ADDRESS		25a. REC'D BY REGISTRAR MAY 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06817					06810				
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE West Virginia				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keyser				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS RFD # 1, Box 7				
3. NAME OF DECEASED (Type or print) First Middle Last ISAAC WALLACE INSKEEP					4. DATE OF DEATH Month Day Year May 26 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-95		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) McCoole, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Inskeep					14. MOTHER'S MAIDEN NAME Goldie Miller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 705-10-0354		17. INFORMANT VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable ventricular fibrillation 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis agitans (Parkinson Disease)								INTERVAL BETWEEN ONSET AND DEATH 15 minutes 4 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Sept. 19, 1962, to May 26, 1966, that (we) last saw the deceased alive on XXXXXXXXXXXXXXXXXX, and that death occurred at 8:43 M from the causes and on the date stated above.									
22a. SIGNATURE B. Rothfeld				22b. DATE SIGNED 5-26-66					
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.				22d. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF May 29, 1966		23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Mem.Pk.		23d. LOCATION (City, town or county) (State) Keyser, W. Va.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.				25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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10 days
4 yrs 8 mos

Party 10-10

Insurance Administration Hospital

Mr. J. L. Jones

ISAD

WALLACE

10-15-32

8-15-32

McDowell, Maryland

Hotel Miller

100-100-10

VA Hospital Records, Party 10-10

Probable venereal infection

Intentional infection

Intentional infection (Gonorrhea)

Sept. 19, 32

E. B. BOWMAN, M.D.

VA Hospital, Party 10-10

MAY 31 1932

10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 17 yrs - 6 Mo 17 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Newburg				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital					d. STREET ADDRESS Rt 1 Box 91			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bennett Middle P. Last JACKSON					4. DATE OF DEATH Month May Day 29 Year 19 66				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 8 15		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 5 Days 29	IF UNDER 24 HRS. Hours 17 Min. 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman			10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (County & State, or foreign country) Morgantown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Sankston Jackson					14. MOTHER'S MAIDEN NAME Emma M. King				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW II 217-14-76-48		17. INFORMANT Address VA Hospital Records - Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA, Bilateral 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Emphysema, Severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3-7 days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that 10 (this hospital) attended the deceased from 11 12 48 , 19 48 , to 5 29 66 , 19 66 , and that death occurred at 3 a M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Benjamin Rothfield</i>					22b. DATE SIGNED 5 29 66				
22c. PHYSICIAN'S NAME (Type) Benjamin Rothfield, MD.					22d. ADDRESS VA Hospital - Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 5-30-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft Myer, Va.		
24. FUNERAL DIRECTOR <i>Charles Judge</i> AREHART FUNERAL HOME - LaPlata, Maryland					25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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Information from birth cert.

06819

CERTIFICATE OF DEATH

06812

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 45 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First Infant Last Johnson		4. DATE OF DEATH Month May Day 1 , Year 1966	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Child	8. DATE OF BIRTH May 1, 1966
9. AGE (In years last birthday) yrs. ---		10. IF UNDER 1 YEAR Months --- Days --- Hours --- Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Cecil		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELMER Johnson		14. MOTHER'S MAIDEN NAME Joyce Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Elmer Johnson, Conowingo, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) In maturity DUE TO (b) 776X DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Ercolini Gresia		22b. DATE SIGNED 5/1/66	
22c. PHYSICIAN'S NAME (Type) Ercolini Gresia, M.D.		22d. ADDRESS Union Hospital, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 4, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Zora Cemetery	23d. LOCATION (City or Town) (County) (State) Conowingo Cecil, Md.
24. FUNERAL DIRECTOR W. P. Johnson, Elkton, Md.		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06818

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06820		06813	
1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Indiana b. COUNTY Evansville	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Evansville	
c. LENGTH OF STAY IN 1b 5 yrs 4 mos.		d. STREET ADDRESS 111 John Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELMER L. JONES		4. DATE OF DEATH Month May Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-01
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 218-54-1447		17. INFORMANT VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia, Bilateral 332X DUE TO (b) Cerebral Infarction (Stroke) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4-7 days 9-10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from Jan. 4 , 19 61 , to May 6 , 19 66 , and that death occurred at 9:30 from the causes and on the date stated above.		22a. SIGNATURE Charles E. Lawson M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED 5-7-66		22c. PHYSICIAN'S NAME (Type) CHARLES E. LAWSON, M.D.	
22d. ADDRESS VAH, Perry Point, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE THEREOF 5/11/1966		23c. NAME OF CEMETERY OR CREMATORY Louden Park	
23d. LOCATION (City, town or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR Pennington & Son Funeral Home, Havre de Grace, Md.	
25a. REC'D BY REGISTRAR MAY 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.									
06821					06814				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arlington				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital					d. STREET ADDRESS 1721 14th St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Melvin Jerome Jones			4. DATE OF DEATH Month Day Year May 18, 19 66						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 15 90		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Arlington, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William (deceased)					14. MOTHER'S MAIDEN NAME Mary (deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 577 38 29 67		17. INFORMANT VA Hospital Records - Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Cachexia 1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Carcinoma Of Large Intestine (Splenic Flexure) 3-6 Months DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1-2 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that if (this hospital) attended the deceased from 4 26 66, 19, to 5 18 66, 19, that it had not last seen the deceased alive on 5 19 66 , and that death occurred at 6pm M, from the causes and on the date stated above.									
22a. SIGNATURE								22b. DATE SIGNED 5 19 66	
22c. PHYSICIAN'S NAME (Type) E.E. FOLK, III, M.D.					22d. ADDRESS VA Hospital - Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5 19 66		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town or county) (State) Ft Myer, Virginia		
24. FUNERAL DIRECTOR CHINN FUNERAL HOME - Arlington, Virginia					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 23 1966 jcharles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3 mo 18 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1818 13th St. N.W. d. STREET ADDRESS 1818 13th St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Cleveland Middle - Last JORDAN			4. DATE OF DEATH Month May Day 26 Year 1966						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 15 14		9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jordan (Deceased)					14. MOTHER'S MAIDEN NAME Flay Williams (Deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW II 578-16-38-15		17. INFORMANT Address VA Hospital Records - Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Esophagus DUE TO (c) 6-10 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7-10 days									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 2 8 66 , 19 to 5 26 66 , 19 that (b) was last seen the deceased alive on 5-19-66 , and that death occurred at 11:10 pm from the causes and on the date stated above.									
22a. SIGNATURE S. Goldgraben								22b. DATE SIGNED 5 27 66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M. D.					22d. ADDRESS VA Hospital - Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 5-31-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Arlington, Va.		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR James R. Snowden Snowden Funeral Home, Rockville, Maryland					25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
06823																	
06816																	
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN 1b 2 hrs. 20 min. Rising Sun d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, USNTC						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 07-1 d. STREET ADDRESS 211 West Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Viola Daisy KEELING						4. DATE OF DEATH Month Day Year May 5 1966											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1966		9. AGE (In years last birthday) yrs. Months Days 2 20		IF UNDER 1 YEAR Months Days 2 20							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland U. S. A.									
13. FATHER'S NAME Douglas Earl KEELING						14. MOTHER'S MAIDEN NAME Jenise Arenthia SPRING											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Hospital Records											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PREMATURITY																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1966		20g. (County) May		20h. (State) 66							
21. I certify that (I) (this hospital) attended the deceased from 5 May 1966 to 5 May 1966 , that (I) last saw the deceased alive on 5 May 1966 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE John L. Norris M.D.						22b. DATE SIGNED 5-6-66											
22c. PHYSICIAN'S NAME (Type) John L. NORRIS LT MC USNR						22d. ADDRESS Station Hospital, USNTC, Bainbridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-6-66				23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery				23d. LOCATION (City, town or county) (State) Colora Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON						25a. REC'D BY REGISTRAR Perryville, Md.						25b. REGISTRAR'S SIGNATURE MAY 9 1966					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and for any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 41 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Hartford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS 160 Darlington Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JACOB F. KELLS			4. DATE OF DEATH May 16 1966		5. SEX Male				
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-91		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Employee (P.O.)			10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Johnstown, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George W. Kells (D)					14. MOTHER'S MAIDEN NAME Sarah Kanuer (D)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW I 210-09-7608		17. INFORMANT VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis, right coronary artery DUE TO (c) Arteriosclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH 5-7 days 2-5- days weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus (15 years)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that W (this hospital) attended the deceased from April 5, 1966 , to May 16, 1966 , that the deceased saw the deceased live on xxxxxxx 19xx , and that death occurred at 1:50 AM from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5-16-66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, MD.					22d. ADDRESS VA Hospital, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 19 May 66		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Md.			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR Connerth B. Cargo Tarring Funeral Home, Aberdeen, Maryland					25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

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FOR STATE HEALTH DEPT

06825

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06818

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural - Elkton d. STREET ADDRESS RD #2 219 Miller Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS JOHN LEE			4. DATE OF DEATH Month Day Year MAY 27 19 66		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 13, 1917		9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 27 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Lee		14. MOTHER'S MAIDEN NAME Mary Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-09-4348		17. INFORMANT Lewis J. Lee Jr. Newark, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 983X IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - auto			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3:22 AM 5-27- 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) (County) (State) Elkton Cecil Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker, MD.		22. DATE SIGNED 5/27/66		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1966		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
23d. LOCATION (City or Town) (County) (State) Elkton, Maryland		24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06826

06819

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN ID 35 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47-3 d. STREET ADDRESS 3500 Clay Place, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL First NMI Middle LIEBER Last		4. DATE OF DEATH May Month 16 Day 19 Year 66					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-94	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Shop		11. BIRTHPLACE (County & State, or foreign country) Roumania			
13. FATHER'S NAME Hain (D)			14. MOTHER'S MAIOEN NAME Celia (unk) (D)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 579-26-2497		17. INFORMANT VA Hospital Records, Perry Point, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Linitis plastica with generalized Metastases 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 6 months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town)		(County) (State)			
21. I certify that XX (this hospital) attended the deceased from April 11 , 19 66 , to May 16 , 19 66 that (b) (two) last saw the deceased alive on XXXXXX and that death occurred at 1:40 from the causes and on the date stated above.							
22a. SIGNATURE <i>I. Reus</i>		22b. DATE SIGNED 5-17-66		22c. PHYSICIAN'S NAME (Type) I. REUS, M.D.			
		22d. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia			
24. FUNERAL DIRECTOR Bernard Danzansky & Sons, 3501 14th St., N.W.		25a. REC'D BY REGISTRAR MAY 20 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

Department of Columbia

Washington

3500 Old Bridge, N.J.

MEMPHIS

4-11-68

Memphis

Re: (S) (S)

350-28-4447 V. Hospital Records, Perry, John, Jr.

Little history with personal references

X

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-83 BY SP-10 J. W. J. A. J.

DATE 11-11-83 BY SP-10 J. W. J. A. J.
MAY 8 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06820									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pratt Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS 07-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Henry R. Love			4. DATE OF DEATH Month May Day 20 Year 1966						
5. SEX M		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 13, 1880		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert J. Love					14. MOTHER'S MAIDEN NAME Lavinia M. Simmers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 218-18-3536				
17. INFORMANT Robert Love, Rising Sun, Md.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD + senile heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (1) (this hospital) attended the deceased from Oct. 1963 , to May 1966 , that (1) (we) last saw the deceased alive on 5-12 1966 , and that death occurred at 6:30 AM , from the causes and on the date stated above. 22a. SIGNATURE Jay S. Barnhart 22c. PHYSICIAN'S NAME (Type) JAY S. BARNHART, I.R. MD 22b. DATE SIGNED 5/23/1966 22d. ADDRESS 3 MAULDIN AVE. NORTH EAST, MD. 22e. REC'D BY REGISTRAR MAY 27 1966 22f. REGISTRAR'S SIGNATURE Charles Judge									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md.		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.					25. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06823					06821				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Grove				
c. LENGTH OF STAY IN 1b LIFE					d. STREET ADDRESS Basin Run Road				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Basin Run Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Ella M. McDowell			4. DATE OF DEATH Month Day Year May 17 1966						
5. SEX F	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 13, 1882	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Oliver R. Morrison				14. MOTHER'S MAIDEN NAME Frances Barrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT Harry O. McDowell, Liberty Grove, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Liver 1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertension, Cardiac, Atherosclerosis DUE TO (c) 15 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 1951, to May 17, 1966, that (I) (we) last saw the deceased alive on May 11, 1966, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE G. H. Richards Jr.			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MEO. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/> 5/20/66		
22c. PHYSICIAN'S NAME (Type) G. H. Richards Jr. M.D.			22d. ADDRESS Port Deposit, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/20/1966		23c. NAME OF CEMETERY OR CREMATORY Harmony Chapel Cem.		23d. LOCATION (City, town or county) (State) Liberty Grove, Md.		
24. FUNERAL DIRECTOR W. H. Patterson Jr.			ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR MAY 27 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06829						06822					
1. PLACE OF DEATH a. COUNTY Cecil County						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Domenico NMI Pascuci						4. DATE OF DEATH Month Day Year May 14, 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unk.		9. AGE (In years last birthday) Approx. 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY COAL		11. BIRTHPLACE (County & State, or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Pascuci						14. MOTHER'S MAIDEN NAME Pastoria Pascucci					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 213-48-3200		17. INFORMANT Address VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho pneumonia both lower lobes of lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (if in this hospital) attended the deceased from Sept. 8, 1922, to May 14, 1966, and that death occurred at 4:25 PM, from the causes and on the date stated above.											
22a. SIGNATURE Benjamin Rothfeld						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-15-66			
22c. PHYSICIAN'S NAME (Type) Benjamin Rothfeld, M.D.						22d. ADDRESS VAH. Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 5/18/1966		23c. NAME OF CEMETERY OR CREMATORY Louden Park National				23d. LOCATION (City, town or county) Balto., Maryland	
24. FUNERAL DIRECTOR Patterson & Son				ADDRESS Perryville, Maryland		25a. REC'D BY REGISTRAR MAY 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

23132

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office of the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06830

06823

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2208 E. Lombard St		d. STREET ADDRESS 2208 E. Lombard Street	
3. NAME OF DECEASED (Type or print) First Herman Middle Ray Last Phillips		4. DATE OF DEATH Month May Day 29 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/18/18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Owens Boat Co	9. AGE (In years lost birthday) 48 yrs.
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Phillips		14. MOTHER'S MAIDEN NAME Mary Hancock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 23603I901	
17. INFORMANT Elsie Phillips as above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found lying in water-had been fishing	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 o.m. 5/29 p.m. 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River
20f. (City or town) Port Deposit		(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 5/30/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/3/66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR <i>Walter Dabrowski</i> ADDRESS 1005 Dundalk Ave.		25a. REC'D BY REGISTRAR JUN 2 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Phone — Med Ex. 6/7/66
Deak on as Carl Co.
- Port Deposit

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06831

06824

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u> c. LENGTH OF STAY IN lb <u>2 hrs. 20 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, USNTC</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u> d. STREET ADDRESS <u>Trailer #63, Bainbridge Village</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Michael (n) PHILLIPS</u>				4. DATE OF DEATH May 12 1966			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1966</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>20</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cecil County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Kenneth Vernon PHILLIPS</u>	
14. MOTHER'S MAIDEN NAME <u>Kathleen Anne Conlan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATURITY</u> DUE TO <u>776 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>-----</u> (c) <u>-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 May 1966</u> to <u>12 May 1966</u> , that (I) <u>WEX</u> last saw the deceased alive on <u>12 May 1966</u> , and that death occurred at <u>6:50 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Miller</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. MILLER, LT MC USNR</u>				22d. ADDRESS <u>Station Hospital, USNTC, Bainbridge, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Coloma, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LEE A. PATTERSON & SON, PERRYVILLE, MD.</u>				25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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CONTINUITY OF PLANT

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CONTINUITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06832 CERTIFICATE OF DEATH 06825														
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5718 3rd Place, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY ROBINSON					4. DATE OF DEATH Month Day Year May 16 1966									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-90		9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baldwin City, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Robert Robinson (D)					14. MOTHER'S MAIDEN NAME Addie (unk) (D)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT VA Hospital Records, Perry Point, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA AND UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 609X DUE TO PELVIC AND PERIURETHRAL AND PERIURETERAL ABSCESS DUE TO (b) FALSE PASSAGES IN THE POSTERIOR URETHRA DUE TO (c) AND CHRONIC PYELONEPHRITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTATIC TUMOR TO PERI AORTIC NODES. A.S.H.D.								INTERVAL BETWEEN ONSET AND DEATH One week 2-3 WKS. UNK.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that XX (this hospital) attended the deceased from May 5 , 19 66 , to May 16 , 19 66 , that the deceased Sam the deceased died on XXXXXXX 19XXXX and that death occurred at 8:20 am from the causes and on the date stated above.														
22a. SIGNATURE MAHER W. ISHAK, M.D.					22b. DATE SIGNED 5-17-66			22c. PHYSICIAN'S NAME (Type) MAHER W. ISHAK, M.D.						
22d. ADDRESS VA Hospital, Perry Point, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 5/19/1966		23c. NAME OF CEMETERY OR CREMATORY Louden Park National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR Lee Patterson Funeral Home, Perryville, Md.					25a. REC'D BY REGISTRAR MAY 27 1966					25b. REGISTRAR'S SIGNATURE J Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06833 CERTIFICATE OF DEATH 06826									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland c. LENGTH OF STAY IN 1b 4yrs8mos14days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo d. STREET ADDRESS 6005 Princeton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARIAN Middle K. Last SEBASTIAN					4. DATE OF DEATH Month May Day 27 Year 19 66				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 18 03		9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Jack (Deceased)					14. MOTHER'S MAIDEN NAME Mertie M. Mosher (Deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 579-12-3116		17. INFORMANT VA Hospital Records - Perry Point, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome associated with Alzheimer's Disease DUE TO (b) Bronchopneumonia DUE TO (c) 305X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from 9 13 61 , 19 a.m. to 5 27 66 , 19 a.m. , and that death occurred at 1250 M. from the causes and on the date stated above.									
22a. SIGNATURE S. Goldbraben					22b. DATE SIGNED 5 27 66			22c. PHYSICIAN'S NAME (Type) S. GOLDBRABEN, M. D.	
22d. ADDRESS VA Hospital, Perry Point, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF May 31, 1966		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Suitland Maryland			
24. FUNERAL DIRECTOR Walters Funeral Home, Baltimore, Maryland ADDRESS 254 Carroll St. W. Wash.					25a. REC'D BY REGISTRAR D.C.		25b. REGISTRAR'S SIGNATURE f Charles Judge		
MAY 31 1966									

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06834					06827				
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 60 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1205-6 1/2 St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Robert Middle L. Last SHAW			4. DATE OF DEATH Month May Day 9, Year 19 66						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-24-10		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Stephens, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Pleas Shaw (D)				14. MOTHER'S MAIDEN NAME Mary Gillum (D)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT VA Hospital Records - Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio vascular disease DUE TO (c) Arteriolar nephrosclerosis								INTERVAL BETWEEN ONSET AND DEATH 7-10 hrs. years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 10 66 , 19 to 5 9 66 , 19 and that death occurred at 2:55 p.m. from the causes and on the date stated above.									
22a. SIGNATURE S. Goldgraben				22b. DATE SIGNED 5 9 66					
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.				22d. ADDRESS VA Hospital - Perry Point, Md.					
23a. BURIAL CREMATION Removal (Specify) Removal		23b. DATE THEREOF 5-13-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft Myer Va			
24. FUNERAL DIRECTOR William Spangler Spangler Funeral Home, 524.8 NE				25a. REC'D BY REGISTRAR MAY 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

06221

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UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

COMMUNICATIONS SECTION

COMMUNICATIONS SECTION

COMMUNICATIONS SECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06835		Item 23b 131m 4377		6/16/66 mh		06828			
1. PLACE OF DEATH a. CDUNITY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28 hours		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA		b. COUNTY ✓	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2395 Elvans Rd. S.E.		47-3	
3. NAME OF DECEASED (Type or print) First Ulysses G. Middle Shelton Last 		4. DATE OF DEATH Month May 29 Day 29 Year 19 66		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-6-95		9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John D. Shelton		14. MOTHER'S MAIDEN NAME Kate		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI	
17. INFORMANT Records		Address VA Hospital - Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, confluent of lower lobes 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelo nephritis, acute, left kidney. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chondrosarcoma, residual of dorsal spine		INTERVAL BETWEEN ONSET AND DEATH 5 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 27 66 , 19 66 , to 5 29 66 , 19 66 , that in the last 24 hours deceased died on 5 29 66 , and that death occurred at 2:20 a.m. , from the causes and on the date stated above.		22a. SIGNATURE Benjamin Rothfeld		22b. DATE SIGNED 5 29 66		22c. PHYSICIAN'S NAME (Type) Benjamin Rothfeld	
22d. ADDRESS VA Hospital - Perry Point, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 6/3/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft Myer, Virginia	
24. FUNERAL DIRECTOR FRAZIER FUNERAL HOME - 4th and Florida Ave.,		25. REC'D BY REGISTRAR JUN 2 1966		25a. REGISTRAR'S SIGNATURE Judge		25b. REGISTRAR'S SIGNATURE Judge		25c. REGISTRAR'S SIGNATURE Judge	

RECORDS OF CONGRESS

1901

Washington

23 March

Henry Point

2333 Avenue A, N.W.

VA Hospital

May 29

Wynne L. Shelton

to

1-0-25

Henry

also

U.S.A.

West Virginia

Local Clerk

State

John L. Shelton

Records

VA Hospital - Henry Point, Va.

277-60-28-00

WPI

Yes

Records transmitted to file of John

Wynne L. Shelton, State, West Virginia.

Records transmitted to file of John

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Records transmitted

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VA Hospital - Henry Point, Va.

Benjamin Shelton

2 West, Virginia

Washington National

Records

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Records transmitted to file of John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH					06829						
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> 07-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>A.</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1966</u>								
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1908</u> 58 yrs.		9. AGE (In years last birthday) Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr.-Ser. Sta.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Howard T. Smith</u>			14. MOTHER'S MAIDEN NAME <u>Grace G. Jackson</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-14-2627</u>		17. INFORMANT <u>Grace H. Smith, Charlestown, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>May</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 21</u> , 19 <u>66</u> , and that death occurred at <u>11:58</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Day I Baruchart</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-23-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Day I Baruchart</u>			22d. ADDRESS <u>North East, Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Principio Furnace, Md.</u>				
24. FUNERAL DIRECTOR <u>W. J. Perry</u>			ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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CERTIFICATE OF DEATH

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06830

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		MARYLAND c. LENGTH OF STAY IN 1b <u>39 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>Belle Hill R.D. 3</u>	
3. NAME OF DECEASED (Type or print) <u>Sara R Spence</u>		First Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1889</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>	
13. FATHER'S NAME <u>Francis Wesley Hess</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Atwell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>R.D. 3</u> <u>Mrs. Charles O. Allen, Elkton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4200 DUE TO (b) <u>Cerebral Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND IDEATH <u>3 days</u> <u>3 days</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>May 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Joseph G. Lanzl</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph G. Lanzl</u>		22d. ADDRESS <u>Elkton Medical Park, Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Townsend Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Townsend, Del.</u>		
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 6 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville				c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital, Perry Point, Md.					d. STREET ADDRESS R.D. 1.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle J Last SPURRIER			4. DATE OF DEATH Month May Day 7 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-97		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter D. Spurrier (Deceased)					14. MOTHER'S MAIDEN NAME Annie Malone (Deceased)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW I 218-07-4559		17. INFORMANT VA Hospital records, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4201 DUE TO (b) Focal broncho pneumonia DUE TO (c) /Arteriosclerotic coronary heart disease Status post laminectomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour 2 days years 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from 4-15-66, 19, to 5-7, 1966, that the deceased died on and that death occurred at 8:00 PM, from the causes and on the date stated above.									
22a. SIGNATURE <i>M. Maher Wahba Ishak</i>								22b. DATE SIGNED 5-8-66	
22c. PHYSICIAN'S NAME (Type) Maher wahba Ishak					22d. ADDRESS VAH Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-removal			23b. DATE THEREOF 5-8-66		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR TYSON FUNERAL HOME					25a. REC'D BY REGISTRAR Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE DATE MAY 10 1966 <i>J. Charles Judge</i>		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>503 Bridge Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann Marie Suggs</u>		4. DATE OF DEATH Month Day Year <u>May 26, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1933</u> 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>Luther Bradley Suggs</u>		14. MOTHER'S MAIDEN NAME <u>Nonie Lee Jacobs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Luther Rudolph Suggs, Clark Summit,</u>		-Address <u>Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic glomerulo-nephritis</u> DUE TO (c) <u>Acute glomerulo-nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 19 <u>66</u> , to <u>5/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5/26</u> , 19 <u>66</u> , and that death occurred at <u>5:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Stavrakis</u>		22b. DATE SIGNED <u>5/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>		22d. ADDRESS <u>ELKTON Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 6 1966</u>	

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EXTRACT OF GRAIN

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No. 1		No. 2		No. 3		No. 4		No. 5		No. 6		No. 7		No. 8		No. 9		No. 10		No. 11		No. 12		No. 13		No. 14		No. 15		No. 16		No. 17		No. 18		No. 19		No. 20		No. 21		No. 22		No. 23		No. 24		No. 25		No. 26		No. 27		No. 28		No. 29		No. 30		No. 31		No. 32		No. 33		No. 34		No. 35		No. 36		No. 37		No. 38		No. 39		No. 40		No. 41		No. 42		No. 43		No. 44		No. 45		No. 46		No. 47		No. 48		No. 49		No. 50		No. 51		No. 52		No. 53		No. 54		No. 55		No. 56		No. 57		No. 58		No. 59		No. 60		No. 61		No. 62		No. 63		No. 64		No. 65		No. 66		No. 67		No. 68		No. 69		No. 70		No. 71		No. 72		No. 73		No. 74		No. 75		No. 76		No. 77		No. 78		No. 79		No. 80		No. 81		No. 82		No. 83		No. 84		No. 85		No. 86		No. 87		No. 88		No. 89		No. 90		No. 91		No. 92		No. 93		No. 94		No. 95		No. 96		No. 97		No. 98		No. 99		No. 100		No. 101		No. 102		No. 103		No. 104		No. 105		No. 106		No. 107		No. 108		No. 109		No. 110		No. 111		No. 112		No. 113		No. 114		No. 115		No. 116		No. 117		No. 118		No. 119		No. 120		No. 121		No. 122		No. 123		No. 124		No. 125		No. 126		No. 127		No. 128		No. 129		No. 130		No. 131		No. 132		No. 133		No. 134		No. 135		No. 136		No. 137		No. 138		No. 139		No. 140		No. 141		No. 142		No. 143		No. 144		No. 145		No. 146		No. 147		No. 148		No. 149		No. 150		No. 151		No. 152		No. 153		No. 154		No. 155		No. 156		No. 157		No. 158		No. 159		No. 160		No. 161		No. 162		No. 163		No. 164		No. 165		No. 166		No. 167		No. 168		No. 169		No. 170		No. 171		No. 172		No. 173		No. 174		No. 175		No. 176		No. 177		No. 178		No. 179		No. 180		No. 181		No. 182		No. 183		No. 184		No. 185		No. 186		No. 187		No. 188		No. 189		No. 190		No. 191		No. 192		No. 193		No. 194		No. 195		No. 196		No. 197		No. 198		No. 199		No. 200		No. 201		No. 202		No. 203		No. 204		No. 205		No. 206		No. 207		No. 208		No. 209		No. 210		No. 211		No. 212		No. 213		No. 214		No. 215		No. 216		No. 217		No. 218		No. 219		No. 220		No. 221		No. 222		No. 223		No. 224		No. 225		No. 226		No. 227		No. 228		No. 229		No. 230		No. 231		No. 232		No. 233		No. 234		No. 235		No. 236		No. 237		No. 238		No. 239		No. 240		No. 241		No. 242		No. 243		No. 244		No. 245		No. 246		No. 247		No. 248		No. 249		No. 250		No. 251		No. 252		No. 253		No. 254		No. 255		No. 256		No. 257		No. 258		No. 259		No. 260		No. 261		No. 262		No. 263		No. 264		No. 265		No. 266		No. 267		No. 268		No. 269		No. 270		No. 271		No. 272		No. 273		No. 274		No. 275		No. 276		No. 277		No. 278		No. 279		No. 280		No. 281		No. 282		No. 283		No. 284		No. 285		No. 286		No. 287		No. 288		No. 289		No. 290		No. 291		No. 292		No. 293		No. 294		No. 295		No. 296		No. 297		No. 298		No. 299		No. 300		No. 301		No. 302		No. 303		No. 304		No. 305		No. 306		No. 307		No. 308		No. 309		No. 310		No. 311		No. 312		No. 313		No. 314		No. 315		No. 316		No. 317		No. 318		No. 319		No. 320		No. 321		No. 322		No. 323		No. 324		No. 325		No. 326		No. 327		No. 328		No. 329		No. 330		No. 331		No. 332		No. 333		No. 334		No. 335		No. 336		No. 337		No. 338		No. 339		No. 340		No. 341		No. 342		No. 343		No. 344		No. 345		No. 346		No. 347		No. 348		No. 349		No. 350		No. 351		No. 352		No. 353		No. 354		No. 355		No. 356		No. 357		No. 358		No. 359		No. 360		No. 361		No. 362		No. 363		No. 364		No. 365		No. 366		No. 367		No. 368		No. 369		No. 370		No. 371		No. 372		No. 373		No. 374		No. 375		No. 376		No. 377		No. 378		No. 379		No. 380		No. 381		No. 382		No. 383		No. 384		No. 385		No. 386		No. 387		No. 388		No. 389		No. 390		No. 391		No. 392		No. 393		No. 394		No. 395		No. 396		No. 397		No. 398		No. 399		No. 400		No. 401		No. 402		No. 403		No. 404		No. 405		No. 406		No. 407		No. 408		No. 409		No. 410		No. 411		No. 412		No. 413		No. 414		No. 415		No. 416		No. 417		No. 418		No. 419		No. 420		No. 421		No. 422		No. 423		No. 424		No. 425		No. 426	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					06833				
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 11 mos. 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 1917 Berry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) THOMAS ALBERT SWAIN			4. DATE OF DEATH May 12 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-13-92		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber's helper			10b. KIND OF BUSINESS OR INDUSTRY County School Board		11. BIRTHPLACE (County & State, or foreign country) North Keys, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John H. Swain (D)				14. MOTHER'S MAIDEN NAME Martha Rawlings (D)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 225-10-1633		17. INFORMANT VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerosis, generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4-7 days 10-12 mos.									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that D (this hospital) attended the deceased from May 29 , 19 65 , to May 12 , 19 66 , and that death occurred at 7:00 am, from the causes and on the date stated above.									
22a. SIGNATURE B. Rothfeld					22b. DATE SIGNED 5-12-66				
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, M.D.					22d. ADDRESS VA Hospital, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal Burial			23b. DATE THEREOF 5/16/66		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery Forest Memorial		23d. LOCATION (City, town or county) (State) Forestville, Md.		
24. FUNERAL DIRECTOR Upper Ritchie Funeral Home, Marlboro, Maryland					25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

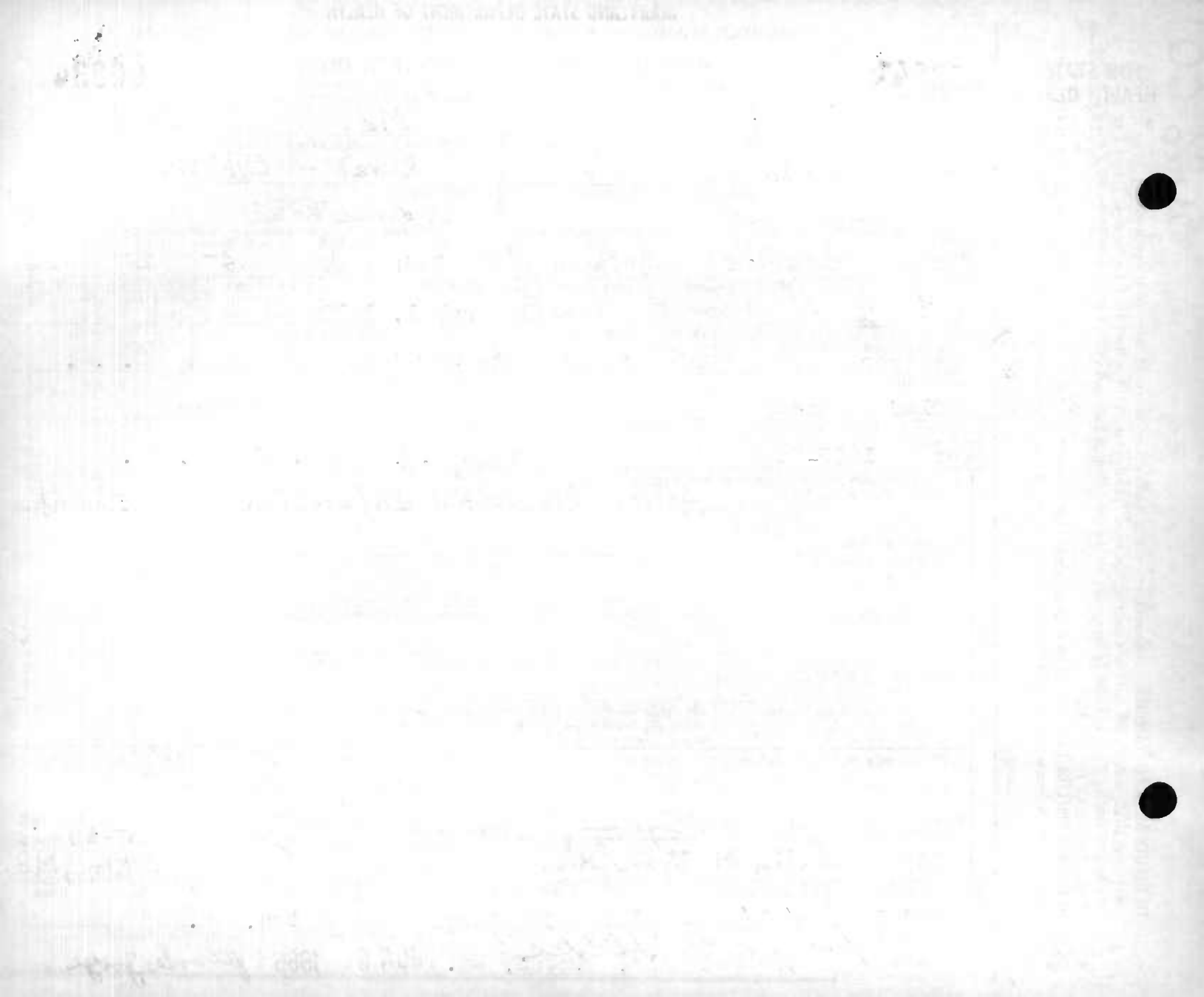
06841

06834

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton 07-1	
c. LENGTH OF STAY IN lb Life		d. STREET ADDRESS Dogwood Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Arthur Swanson Last		4. DATE OF DEATH Month 5 Day 27 Year 1966	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1910
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ordnance Products	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Olaf Swanson		14. MOTHER'S MAIDEN NAME Mary Amelia Foracker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. L935-38	
17. INFORMANT Frank O. Swanson, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			INTERVAL BETWEEN ONSET AND DEATH Immed.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byens, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John M. Byens, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/31/66	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	23d. LOCATION (City or Town) (County) (State) Elkton, Md.
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR JUN 6 1966	25b. REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06842					06835				
Item 230 Film 5377 5/31/66 mh									
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Ind. City				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Richmond				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 7102 Fountain Avenue				
3. NAME OF DECEASED (Type or print) First Middle Last PURCELL L. TRUEHEART					4. DATE OF DEATH Month Day Year 5 18 1966				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-26		9. AGE (In years last birthday) 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (County & State, or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME EDWARD TRUEHEART					14. MOTHER'S MAIDEN NAME GAYNELL LIPSCOMB				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes give war or dates of service) WWII		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Diffuse Peritonitis. 5401 DUE TO Perforated Gastric Ulcer (b) DUE TO Penetrating Chronic Gastric Ulcer (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 6 To 12Hrs. 6 To 12Hrs. Months(?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from 5-31, 1951, to 5-18-1966, and that death occurred at 7:05 AM from the causes and on the date stated above.									
22a. SIGNATURE Thomas P. Thompson M.O.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-66		
22c. PHYSICIAN'S NAME (Type) THOMAS P. THOMPSON, M.D.					22d. ADDRESS VA Hospital - Perry Point, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/20/66		23c. NAME OF CEMETERY OR CREMATORY National Cemetary		23d. LOCATION (City, town or county) (State) Richmond, Virginia			
24. FUNERAL DIRECTOR W. I. Johnson Funeral Home, Richmond, Va.					25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Source: *Library of Congress*

Figure 2

2. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06843					CERTIFICATE OF DEATH					06836				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen					d. STREET ADDRESS RD 2 Box 3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Edward Middle E. Last VICARI					4. DATE OF DEATH Month May Day 25 Year 19 66									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-10-92		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Michael Vicari (D)						14. MOTHER'S MAIDEN NAME Rose Geraci (D)								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 213-09-88-88		17. INFORMANT VA Hospital Records - Perry Point, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that VA (this hospital) attended the deceased from 5 13 66 , 19 to 5 25 66 , 19 from 11:40 pm , and that death occurred at 11:40 pm from the causes and on the date stated above.										22b. DATE SIGNED 5-26-66				
22a. SIGNATURE B. Rothfeld				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. B. ROTHFELD, M.D.				22d. ADDRESS VAH, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 May 66		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Md.				23d. LOCATION (City, town or county) (State)						
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md.						25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						

10000

Local

Long Point

12 days

Albion

VA Hospital

ED 2 sec 3

Howard

E.

VICARIO

White

Male

1-10-92

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Michael Victor

(D)

Long Point

WM I

Yes

113-02-88-85

VA Hospital Records - Long Point, MD.

Microfilm

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Microfilm

Printed

28 May 90

Baltimore National Cemetery, Baltimore, MD.

MAY 11 1990

Long Point, MD.

06844

CERTIFICATE OF DEATH

06837

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 3 yrs.		d. STREET ADDRESS R.D. # 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Walker		4. DATE OF DEATH Month Day Year May 20, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1900
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Produce Market	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Walker		14. MOTHER'S MAIDEN NAME Ruth -- --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. R.D. # 2	
17. INFORMANT Mrs. Beulah H. Walker, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Post op. Prostatectomy BPH DUE TO (c) Pulmonary emphysema			
INTERVAL BETWEEN ONSET AND DEATH 8 hrs 36 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-9-66 , to 5-20-66 , that (I) (we) last saw the deceased alive on 5-20-1966 , and that death occurred at 8:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Tillman D. Johnson M.D.		22b. DATE SIGNED 5-26-66	
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.		22d. ADDRESS 123 Singler Ave, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/24/66	23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Harsh E. Hicks		25a. REC'D BY REGISTRAR MAY 27 1966	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

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